Phone: 574-825-5666
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Participant Application

Updated 4/28/2023

Participant Info

Participant's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

School: _____ Ethnicity: _____

Age: _____ Height: _____ Weight: _____ Gender: _____

Legal Representative Info

If other than parent, please provide legal documentation*

Legal Representative Name: _____

Address (If different from participant): _____

Phone: _____ Email: _____

I am the: ☐ Parent ☐ Guardian ☐ Case Manager ☐ Other: _____

Health History

Diagnosis/Disability: _____

Does the participant have any of the following health conditions?

☐ Abusive/violent behaviors ☐ Orthopedic restrictions ☐ Braces/prosthetics ☐ G-Tube

☐ Weakness in the extremities ☐ High blood pressure ☐ Hearing impairment ☐ Respiratory condition

☐ Weight lifting restrictions ☐ Heart condition ☐ Vision impairment ☐ Seizures

☐ Allergies: _____

Current Medications (Including over the counter meds): _____

_____

Describe the participant's disabilities in the following areas and include assistance or equipment needs:

Function (Example: mobility skills, walking, motor skills, holding objects, communication, speech)

Social (Example: difficulty relating to others, aggressive behaviors, fearful)

I attest that all the information above is true and accurate.

Legal Representative Signature: _____

Authorization for Emergency Medical Treatment

In case of an emergency LoveWay is authorized to secure emergency medical treatment including but not limited to: x-rays, surgery, hospitalization, and medication as recommended by the attending emergency medical personnel. I also agree to the release of any medical records necessary for the timely treatment of a medical emergency.

Consent is required to participate in LoveWay services.

☐ I consent ☐ I do NOT consent Legal Representative Signature: _____

Preferred Hospital: ☐ Goshen Health Hospital ☐ Elkhart General Hospital ☐ Other: _____

Health Insurance & Policy Number: _____

Medication Allergies: _____

Emergency Contacts ***Please list one person who does not live in your house***

Name & Relation to Participant: _____ Phone: _____

Name & Relation to Participant: _____ Phone: _____

Physician: _____ Phone: _____

Photo & Media Release

LoveWay, Inc. and/or the local media may use any photos or videos taken of myself/participant/family members during LoveWay, Inc. related activities for promotional, educational, or program use.

☐ I consent ☐ I do NOT consent Legal Representative Signature: _____

Waiver Agreement & Liability Release

My signature below denotes that I agree to all the following as a condition for myself, my children, and my family as it pertains to LoveWay, Inc. (hereafter referred to as the "Center") as a condition for participation in activities at/on/near the Center's premises and property or associated with any Center activity including but not limited to: equine assisted activities, trail riding, arena instruction, barn & pasture activities, demonstrations and public events. **WARNING: Under Indiana law, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.** As the legal representative of the participant (myself/child/family), I acknowledge the risks and potential for risks of equine related activities. I understand not all risks can be foreseen nor prevented. I understand these risks and assume responsibility for them. **I hereby, intending to be legally bound for myself, my children and my family, heirs and assigns, executors or administrators, waive and release forever all claims, liabilities and damages (present or future) against LoveWay, Inc., its Board of Directors, Executive Director, Instructors, Staff, Volunteers, Agents and/or other authorized persons for any and all injuries/losses sustained, directly or indirectly while participating and/or visiting at LoveWay, Inc.** As consideration for the Center to allow myself, my children, my spouse and my family members to engage in Center related activities, I agree to assume full responsibility for any and all bodily injuries, losses, claims, liabilities, or damages, which I or they might sustain.

It is mutually understood and agreed that the waiver and liability release set forth in this document constitutes a waiver of liability beyond the provisions of the Indiana Equine Activity Liability Act. I further agree to indemnify and hold harmless the Center or persons/entities associated with the Center and to not bring any claim or suit against them on the basis of any exception to the IN Equine Act. Should I breach any part of this waiver/liability release, I agree to pay all of the Center's attorney's fees or other legal costs that may occur.

I attest that I am at least 18 years of age, of sound mind, not suffering from shock or under the influence of alcohol, drugs or intoxicants. I have read this ENTIRE waiver and application and fully understand it. I intend for this waiver, agreement and liability release to be valid and binding today and at ALL FUTURE TIMES. I attest that all the information I have provided in this application/medical history is true and accurate. My signature denotes agreement with ALL the information on both sides of this form.

Legal Representative Signature: _____ Date: _____

Legal Representative Printed Name: _____